PROVIDER ENROLLMENT AND REGISTRATION FORM

Transaction Code (Circle 1 Only) **A** Add **C** Change **X** Close **Effective Date of the Transaction** ____/____/____ (mo, day, year)

Resource Identification Number (Use on change/close transactions only) _/ _/ _/ _/ _/ _/ _/

Section 1

__/ __/
PROVIDER'S NAME (Please Note: If you are reporting income with a Social Security Number, use your name here not the name of your business. If you are reporting income with an Employer Identification Number, use your business name here.)
__/ __/
DOING BUSINESS AS (DBA) Complete this line only if you report income to the IRS under your Social Security Number. Also complete your name above.
__/ __/ - __/ __/ __/ __/ __/ __/ __/ **OR** __/ __/ __/ - __/ __/ - __/ __/ __/ __/
Employer Identification Number (EIN) Social Security Number (SSN)

Section 2

__/ __/
Provider's Local Address (Street)
__/ __/ __/ __/ __/ __/ __/ __/ __/ __/ __/ __/ __/ __/ __/ __/ __/ - __/ __/ __/ __/
Provider's Local Address (Town/City) State Zip Code
__/ __/
Provider's Billing or Mailing Address (Street)
__/ __/ __/ __/ __/ __/ __/ __/ __/ __/ __/ __/ __/ __/ __/ __/ __/ - __/ __/ __/ __/
Provider's Billing or Mailing Address (Town/City) State Zip Code

PLEASE NOTE: All provider payments are directed to the Provider's Billing or Mailing Address. If you are a provider who forwards payments to a separate billing address or corporate headquarters, you must indicate the correct billing address above to avoid delays in payment.

__/ __/
Provider Contact Person (first and last name)
__/ __/ __/ - __/ __/ __/ - __/ __/ __/ __/ __/ __/ __/ __/ __/ __/ __/ __/ __/ __/ __/ __/
Contact Person's Telephone Number Provider's Telephone Number (if different than contact person)

Section 3

Services Provided: Circle Appropriate Number(s)

01 Child Care Registration Fee	06 Automobile Repair	12 Driver's License Fee	17 Public Private Carrier
02 Education/Training Fee	07 Transportation	13 Dental Care	30 Child Care-Contracted
03 Books/Supplies	08 Tuition	14 Office Clothing	31 Child Care-Licensed
04 Uniforms	10 Auto Insurance Fee	15 Personal Care	32 Child Care-Unlicensed
05 Tools of the Trade	11 Auto Registration Fee	16 EO-Other	

Local and State Office Use Only

Child Care Provider Registration Number:
__/ __/ __/ __/ __/

DO/NHEP Location (town):
__/ __/ __/ __/ __/ __/ __/ __/ __/ __/

_____ _____
District Office/NHEP Signature Date

SR 02-23
(3YC)

INSTRUCTIONS FOR COMPLETION OF PROVIDER ENROLLMENT AND REGISTRATION PROCESS

All providers of goods, services and child care who wish to receive payment from the Department of Health and Human Services (DHHS) must be enrolled and are subject to all Department rules, regulations, policies, and procedures. Child care providers must be registered as well. This is done simultaneously with completion of this form and an Alternative W-9 Form. No payments will be made to any provider until the enrollment process has been completed. **DHHS does not withhold tax money for individuals receiving payments for services. Payment of taxes are responsibility of the individual.**

Enrollment and Billing: At time of enrollment, all providers will be assigned a **Resource Identification (ID) Number** and **Key Name.** Child Care providers will be assigned a **Registration Number** as well. A **Provider Enrollment Notice** will be sent informing you that the enrollment and/or registration process has been completed.
Please retain this notice! The Provider Notice will give you the information we require to be entered on all billing invoices that you submit to DHHS. **To obtain reimbursement for goods or services, you must bill on DHHS billing invoices.**

Reporting Changes: Providers are required to report all changes to DHHS such as changes of address, incorporation of provider name. Changes must be reported to DHHS by submitting them on a *new Form 251 and Alternate W-9 Form-CIS* to the address listed below.

Form Completion

Transaction Code A - Circle when you request a new enrollment.
Transaction Code C – Circle when you report a change or request to provide a new service.
Transaction Code X – Circle when you request to close your enrollment or close a service.
Resource ID Number - Enter your Resource ID number when you report a change or request an enrollment closing. Enter your number from left to right leaving unused spaces blank.
Effective Date – Enter month, day, year. This date will be your first date of enrollment, date services will be provided by you, the effective date of your change, or your enrollment end date.

Section 1

Provider Name - **This line must be completed whether you report income under your SSN# or EIN#**
Enter your **own name** here if you report income to the IRS under your Social Security Number
Enter the **name of your business** here if you report income to the IRS with an Employer Identification Number.

Doing Business As - Complete this line only if you report income to the IRS under your Social Security Number. Enter the name of your business.

Employer ID Number or Social Security Number- Enter the number you use to report income to the IRS (Enter **only one** number – either the SSN# or the EIN#).

Section 2

Provider Address **- Enter your billing or mailing address. (See note on front of this form)**

Contact Person - Enter the name and telephone number of the person we may call for question.

Section 3

Services Provided – **Circle all services you provide. (EO-Other should not be circled unless you have been specifically approved for this service)**

Return this form, along with a completed *Alternate W-9 Form-CIS* to the:

Department of Health and Human Services
Bureau of Data Management
Box 2000
Concord, NH 03302-2000